STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155768	A. BUILDING _____ B. WING _____	03/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE PROTESTANT HOME INC	3701 WASHINGTON AVENUE EVANSVILLE, IN47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure survey, completed on 1/14/11. This visit was in conjunction with the Investigation of Complaint IN00087025. Survey Dates: March 7 and March 8, 2011 Facility Number: 001125 Provider Number: 155768 AIM Number: N/A Survey Team: Diane Hancock, RN,TC Sue Webster, RN Jodi Meyer, RN Census Bed Type: SNF= 42 NCC [Non Certified Comprehensive]=13 Residential=66 Total= 121 Census Payor Type: Medicare=15 Other= 106 Total=121 Sample: SNF 9 NCC 1	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Residential Sample: 5 Evansville Protestant Home, Inc. was found to be in compliance with 42 CFR Part 483, Subpart B in regard to the PSR to the Recertification and State Licensure Survey. Quality review completed on March 9, 2011, by Bev Faulkner, RN This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure survey, completed on 1/14/11. This visit was in conjunction with the Investigation of Complaint IN00087025. Survey Dates: March 7 and March 8, 2011 Facility Number: 001125 Provider Number: 155768 AIM Number: N/A Survey Team:			

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	Diane Hancock, RN,TC Sue Webster, RN Jodi Meyer, RN Census Bed Type: SNF= 42 NCC [Non Certified Comprehensive]=13 Residential=66 Total= 121 Census Payor Type: Medicare=15 Other= 106 Total=121 Sample: SNF 9 NCC 1 Residential Sample: 5 Evansville Protestant Home, Inc. was found to be in compliance with 42 CFR Part 483, Subpart B in regard to the PSR to the Recertification and State Licensure Survey. Quality review completed on March 9, 2011, by Bev Faulkner, RN			

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F9999		F9999	NA	03/18/2011

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R0000	The following Residential Finding was cited in accordance with 410 IAC 16.2-5.	R0000		

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R0214	Based on record review and interview, the facility failed to ensure 1 of 1 resident reviewed for an elopement, in the residential sample of 5, was fully evaluated for a risk for elopement when his condition changed. The resident subsequently left the facility and crossed a busy street. (Resident #128) Finding includes: Resident #128's clinical record was reviewed on 3/8/11 at 9:00 a.m. The resident was admitted to the facility, on 10/29/10, with diagnoses including, but not limited to, atrial fibrillation (irregular heart rate), dementia, multi-infarct dementia, expressive aphasia (difficulty finding or speaking of words), and a history of falls. Nurses' notes included, but were not limited to, the following: 1/30/11 0100 [1:00 a.m.] "Resident [up] ambulating the apt. [apartment] halls. Resident fully dressed. Resident states, 'dressed for church.' Explained to resident it was to (sic) early et rest for 5 to 6 hours. Resident states, 'yes.' Resident returned to apt." 2/9/11 1300 [1:00 p.m.] "Resident has been walking out in the hall frequently today and appears to be very anxious.	R0214	**What corrective action will be accomplished for resident found to be affected by deficient practice?** An evaluation of residents needs was completed and care conference held with family. The physician was notified of the change in condition and did not give orders for the resident to be admitted to nursing. The resident received psychological evaluation and was awaiting placement. The resident' s family had taken him LOA to see his dying sister. The facility feels resident 128 was upset from the weekend's events and attempted to go see his sister again the day he walked across the street to the hospital. Resident 128 has transferred to receive inpatient evaluation at Serenity on 2-22-11 and after treatment there was taken home with his daughter. Resident 128 no longer resides in this facility. **How other residents potentially affected will be identified and corrective actions taken**? All residents have the potential to be affected by the cited deficiency. An update of each resident's service plan shall be completed by the Director of Nursing or designee. A new service plan has been developed for licensed nursing assessment in the residential setting. The new tool assesses mobility, transfer, eating, nutrition, hygiene/dressing, toileting,	04/07/2011

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	Attempted to speak with resident about any concerns unable at this time to understand what resident was attempting to say. Offered to contact family for resolution resident stated no. Pointed to calendar and counted to six. Will attempt to resolve issue." 2/10/11 0830 [8:30 a.m.] "resident ate breakfast in dinning (sic) room this a.m. then attempted to speak with this nurse unable to understand resident's question at this time. Stated my home threw out asked if he still had his home he stated yes will speak with daughter and social services notified at this time." 2/10/11 1400 [2:00 p.m.] MD [medical doctor] updated on increase in aggitation (sic) and up walking in hallway at night as well as frustration due to communication needs awaiting further instruction." 2/11/11 0001 [12:01 a.m.] "Up walking in halls. States came out for breakfast. Dressed in street clothes. Gait steady. Reminded of time; returned to apt." 2/11/11 12:50 p.m. "...Rec'd [received] orders per Dr. [name] for [lab work] and psych [psychiatric] eval [evaluation]...continues to be confused at this time...." 2/12/11 at 1655 [1700] [5:00 p.m.] Dr. [name] ret'd [returned] call to facility N.O. [new order] rec'd clarification Psych eval [name of inpatient psych facility] to		housekeeping, activity, hearing/vision, decision making, mental status, medications, behavior, pain, physical health, and height/weight/vitals. The tool shall be completed on all residential level of care residents currently residing in the apartment setting. The new service plan indicates in each section when it is appropriate to, “assess for nursing care”. All residents who trigger in an area marked “assess for nursing care” will have additional assessment completed with the physician and family notified of the potential change in condition and potential need for placement in nursing. Additional documentation shall be completed in the nursing notes to justify continued placement in the residential setting or the need to transfer to nursing. **What measures will be put in place or systemic changes made to ensure the deficient practice does not recur?** To enhance currently complaint operations, under the direction of the Director of Nursing or designee all licensed nursing staff shall receive in-servicing regarding the completion of the service plan and change in facility policy. The Service Plan policy has been updated to read, “Residential residents of the Evansville Protestant Home will complete a service plan within 24 hours of admission, every three months,	

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	eval when available." 2/18/11 0020 [12:20 a.m.] "Resident ambulating apt. hallway. Resident returned back to apt." 2/18/11 0635 [6:35 a.m.] "Resident [up] ambulating to DR [dining room] for breakfast." 2/18/11 2210 [10:10 p.m.] "Resident has not wandered halls as of this time. Will continue to observe." 2/19/11 0030 [12:30 a.m.] "Resident sitting @ the door waiting for family to pick him up. Resident going LOA [leave of absence] this morning. Resident confused about time. Redirect resident about time et going back to apt. Will continue to monitor." 2/19/11 0100 [1:00 a.m.] "Resident back in the apt. [No] wandering @ this time." 2/19/11 0600 [6:00 a.m.] "Resident [up] doing laundry. resident back in his apt." 2/21/11 0700 [7:00 a.m.] " [Up] ambulating hallways since 0600..." 2/21/11 1500 [3:00 p.m.] "Resident moved to SN 25B [Skilled Nursing] for safety D/T [due to] [decreased] cognitive awareness. Dr. [name] informed of move et order rec'd. Code Alert [to prevent wandering off of unit] bracelet applied D/T [decreased] cognitive awareness et fear of exit seeking behavior from family..."		and with changes of condition." All new admissions will be noted on the 24 hour report by the licensed nurse and a copy of the initial service plan placed with the 24 hour report for review. The facility service plan assessment tool has been expanded to include: mobility, transfer, eating, nutrition, hygiene/dressing, toileting, housekeeping, activity, hearing/vision, decision making, mental status, medications, behavior, pain, physical health, and height/weight/vitals. The new service plan indicates in each section when it is appropriate to, "assess for nursing care". All residents who trigger in an area marked "assess for nursing care" will have additional assessment completed with the physician and family notified of the potential change in condition and potential need for placement in nursing. Additional documentation shall be completed in the nursing notes to justify continued placement in the residential setting or the need to transfer to nursing. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** In addition to the routine daily review of the 24 hour report the Director of Nursing or designee shall review all new admission within 24 hours for completion of the service plan upon admission, every 3 months, and with a change in condition.	

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	Social Service notes included, but were not limited to, the following: 2/9/11 [no time] "[Resident's name] has exhibited [increased] anxiety et frustration - unable to voice thoughts to staff this date." 2/10/11 [no time] "SS [social service] spoke [with] dgt. [daughter] [name] regarding an incident where he threw his fried green beans at the dietary staff although he had ordered them. SS also talked to dgt. regarding his [increased] frustrations speaking thoughts, he is not sleeping, out of room at night in hallways. He has exhibited aggression by hitting at bulletin board et throwing the green beans. MD notified also." 2/16/11 [no time] "SS [and] nsg. spoke with res. family of [resident's name] regarding the conclusion by the psychiatrist that [the resident] benefit from inpatient therapy, related to recent events of anxiety, impulse control, frustrations and not sleeping. Family aware of recent events and they are taking him LOA this weekend to visit his dying sister for the last time that the inpatient placement next week would be beneficial to him he has shown displeasure with them also...Family will transport to Serenity when a bed is available." 2/21/11 [no time] "[Resident's name] was located by staff off the facility grounds		The Service Plan audit shall be monitored 5 times a week for 4 weeks, 3 times a week for 4 weeks, and weekly for four weeks and then monthly to ensure there are no new admissions or changes in condition without an updated service plan implemented by the licensed nurse. Any variation in notation, protocol or processing will result in immediate correction. All audits shall be submitted to the Quality Assurance Committee for review and/or further corrective action. Audits will not titrate down unless QA committee deems 100% compliance was achieved. **Completion Date: 4-07-11**	

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	this date. He returned to the facility and is in nsg. care. He has a code alert..." The Social Worker was interviewed, on 3/8/11 at 10:30 a.m. She indicated the resident had experienced a change, increased anxiety, impulse control, frustration and walking the halls at night and the resident was waiting for an inpatient bed at a local psychiatric unit. The facility's investigation indicated the following: "At 1:15 p.m. south apt. unit manager stated that AD [Activity Director] came in from lunch and said I saw Mr. [resident's name] crossing road out in front of building. Because he's an apt. resident nurse asked me if we should go out and get him. The answer was yes. When he was spotted less than 10 minutes later at [Name of hospital across the street] under an awning, it was raining and he smiled @ [the nurse] got in her car and returned to the facility." "His aphasia has made him more frustrated lately than usual. He was evaled [evaluated] by [inpatient psychiatric] unit for medication adj. [adjustment] related to impulse control. This occurred Friday. He routinely walks outside. Family took him to hospital this wknd [weekend] to see his dying sister."			

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